HIPAA Health Care Eligibility Benefit Inquiry and Response (270/271)
User and Companion Guide for the Extranet

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1 Introduction

1.1 Scope

The purpose of this document is to define the Medicare Eligibility inquiry by Providers and the corresponding response sent per the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In order to implement the HIPAA administrative simplification provisions, the 270/271 has been named under 45 CFR 162 as the Electronic Data Interchange (EDI) standard for Health Care Eligibility Benefit Inquiry/Response.

The software is based on the ANSI ASC X12N 270/271 version 004010X092A1 implementation guide that may be found at the following web site: www.wpc-edi.com/HIPAA. The 270/271 is a "paired" transaction (the 270 is an in-bound eligibility inquiry and the 271 is an out-bound eligibility response).

The Final Rule adopting changes to the HIPAA Electronic Transactions and Code Set Standards was published in the Federal Register on February 20, 2003. The URL Link to the Federal Register is: http://www.access.gpo.gov The modifications are published as Addenda to the ASC X12 Implementation Guides and are available and can be downloaded through the Washington Publishing Company website at http://www.wpc-edi.com.

This instructional manual has two purposes. The first purpose is to educate the user on how to access the system. The second purpose is to educate the user on how to send and read eligibility inquiries and responses using the 270/271 formats and convey all Medicare required business rules and information to interpret the information being received.

Providers and Clearinghouses may implement a real-time ANSI ASC X12N 270/271 version 004010X092A1 eligibility inquiry/response to request coverage information from Medicare on patients for whom services are scheduled or services have already been delivered. Providers and Clearinghouses will be referred to as “Trading Partners” throughout this document.

1.2 System Overview

The system will provide access to Medicare beneficiary eligibility data in a real-time environment. In a real-time mode, the Trading Partner transmits a request transaction either directly or through a switch (clearinghouse), and remains connected while the receiver processes the transaction and a response is returned.

Trading Partners will acess the CMS Data Center via the CMS AT&T communication Extranet (the Medicare Data Communication Network or MDCN) to send their eligibility request. This Extranet is a secure closed private network currently used to transmit data between Medicare Fee-for-Service (FFS) contractors and CMS.

For a 270 real-time inquiry, the software at the CMS data center will translate the incoming 270, perform validations, request Beneficiary eligibility information from the CMS eligibility database, and create either a 271, 997, TA1 or a proprietary response.

CMS will continue to hold the Clearinghouses responsible for the privacy and security of eligibility transactions sent directly to them from Providers, and requires them to be able to associate each inquiry with a Provider. Provider authentication must be established outside of the transaction. Trading Partners must not send User IDs and passwords within the 270 eligibility transaction.

2 Electronic Data Interchange (EDI) Registration

2.1 Access Process for Clearinghouses/Provider

To obtain access to the MDCN via the Extranet, Clearinghouses and Providers must complete the 270/271 Access Form that can be found on the CMS website at *WWW.CMS.HHS.GOV/IT*. The 270/271 Access Form should be completed in full and submitted electronically. The electronic submitted form will be directed to both CMS staff and the CMS' Medicare Eligibility Integration Contractor (MEIC).

2.2 Establish Submitter ID

CMS staff will ensure that all of the necessary information is provided on the form, as well as ensure the complete connectivity to the 270/271 application. The MEIC will be responsible for contacting the Trading Partners to authenticate the accessing entity's identity. Once authentication has been completed, the MEIC will provide the Trading Partners with a submitter ID that is required to be used on all 270/271 transactions. Testing will be coordinated by the MEIC. After successful testing, 270 production inquiries may be sent real-time. Please note that in order to access the MDCN, an entity must on its own obtain the necessary telecommunication software from the AT&T reseller.

The current AT&T resellers and contact numbers are listed below:

IVANS: *www.ivans.com*
1-800-548-2675

McKesson: *www.infosolutions.mckesson.com*
1-800-782-7426, option 5, and then key option 8

3 Helpdesk Access and Support

The Medicare Customer Assistance RE: Eligibility () Help Desk will be available from 7:00 AM to 9:00 PM EST, Monday - Friday. The Help Desk is the single point of contact for all questions or concerns about the system.

The Contact Number for Help Desk is 1-866-324-7315.
The email address for the helpdesk is: HD@Webmd.net.

3.1 Testing Requirements

Trading Partners are required to submit test transactions to ensure that their systems creating and transmitting the data are HIPAA and X12 compliant. Each Trading Partner can submit up to 50 test transactions during the testing phase. Trading Partners must call the Help Desk to coordinate test data and testing procedures.

Trading Partners must receive X12 HIPAA compliant 271 responses for all their test transactions to gain access for production submission. A 997, TA1 or Proprietary response received on any of the test 270 transaction will not be accepted as valid testing.

Trading Partners can call the Help Desk for assistance in researching problem transactions. The Help Desk will not edit Trading Partner eligibility data and resubmit transactions for processing.

4 Eligibility Reporting Instructions

The Centers for Medicare and Medicaid Services (CMS) will implement the 270/271 transaction set as a real-time transaction for a single request. The data available through this transaction set will allow a provider to verify an individual's Medicare eligibility and benefits.

Trading Partners and CMS will comply with the following:

- Each transaction will contain only one Patient Request. Each 270 can have only one ISA-IEA, one GS-GE, one ST-SE and a single 2100C subscriber Loop.
- The system will ignore dependent level data if sent with a 270 request and will return response only for the Subscriber level information.
- The system will respond with current eligibility information if no specific date request is made.
- The system will return core eligibility information if no Service Type code is sent on the 270. See Appendix 'A' for core eligibility data elements.
- The response is based on information obtained from the CMS database at the time of inquiry and is not considered a guarantee of payment.

4.1 Real Time Communications Transport Protocol

Communications through the Extranet to the CMS data center will be via the TCP/IP streaming socket protocol. Trading Partners can submit multiple 270 transactions; it will not be necessary to wait for a response before triggering the next 270. Trading partners must ensure that the session remains connected until all responses are received. Each submitted transmission shall contain one 270 transaction with only one ISA and IEA segment, along with a transmission wrapper around the 270 transaction. The transmission wrapper Header/Trailer has no Segment

ID associated with it and requires the length of the transaction message. There will be no handshake after the connection is accepted with the first submitted transmission.

Outbound response transactions will have the same format transmission wrapper. The response to the submitter will be returned in the same session in which the 270 was submitted.

Standard format of the TCP/IP Communication Transport Protocol Wrapper:

SOHLLLLLLLLLLSTX<HIPAA 270 Transaction>ETX

SOH = Required (1 positions), must be EBCDIC or ASCII - 01
LLLLLLLLLL = Required (10 positions), Right justified with zero padded
Note: Length of the HIPAA 270 transaction not including Transmission wrapper data.
STX = Required (1 positions), must be EBCDIC or ASCII - 02
<HIPAA 270 Transaction> = Required (HIPAA 270 – ISA-IEA)
ETX = Required (1 positions), Must be EBCDIC or ASCII -03

Notes: For more detail about SOH, STX and ETX see the Health Care Eligibility Benefit Inquiry and Response 270/271 ASC X12 Extended Control Set in the ASC X12 Standards for Transactions 270/271 004010X092A1 Implementation Guide.

4.2 Eligibility Search Options

The Subscriber Level (Loop 2100C) must contain the Patient Information to query Medicare eligibility. The following data elements are required to search and identify a Medicare beneficiary:

- Patient's Medicare Number (HICN)
- Patient's Full First Name
- Patient's Full Last Name
- Patient's Date of Birth

If all four of these elements are present, a response will be generated if the patient's Medicare number is found in the database. If the patient's Medicare number is not found, or one or more of the above data elements have mismatch, the system will generate appropriate AAA03 errors in the 271 response.

4.3 Interchange Envelope and Functional Group Structures

Trading partners should follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgement (TA1) and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendices A and B. Trading partners must also follow the basic character set guidelines as set forth in the implementation guide for creating the transactions.

Trading Partners must use the preferred delimiters conveyed to CMS during the EDI Registration process. The system will always construct 270 responses with the delimiters agreed upon during the EDI Registration process. If Trading Partner sends a 270 transaction with delimiters other than what was agreed upon, a TA1 error message for invalid delimiter will be returned.

Trading Partners will receive a 271 2100A AAA03=42 response when the system is unable to process a single transaction under a minute. If the incoming 270 transaction is not X12 compliant, then the 271 response may be non X12 compliant.

The following are specific requirements for the ISA and GS Headers:

Segment/ Element	Attributes			Element Name	Instruction
ISA	**Interchange Control Header**				
ISA01	R	ID	2/2	Authorization information Qualifier	00 – no Authorization information must be present in ISA02
ISA02	R	AN	10/10	Authorization information	blanks
ISA03	R	ID	2/2	Security Information Qualifier	00
ISA05	R	ID	2/2	Interchange ID Qualifier	ZZ – Mutually Defined
ISA06	R	AN	15/15	Interchange Sender ID	Trading Partner Submitter ID
ISA07	R	ID	2/2	Interchange ID Qualifier	ZZ – Mutually Defined
ISA08	R	AN	15/15	Interchange Receiver ID	‘CMS ‘
ISA14	R	ID	1/1	Acknowledgment Requested	0 = No Acknowledgment Requested. CMS will not acknowledge receipt of real time transaction and will process the transaction even if acknowledgement is requested.
GS	**Functional Group Header**				
GS02	R	AN	2/15	Application Sender’s Code	Trading Partner Submitter ID
GS03	R	AN	2/15	Application Receiver’s Code	CMS

4.3.1 Information Source Level Structures

CMS will be the Information Source for all Medicare Eligibility Transactions. Providers and Clearinghouses must submit the BHT03 reference identification to uniquely identify each transaction. Trading partners must follow the specific requirements for the BHT and Information Source:

Loop	Segment Element	Attributes	Element Name	Instruction
Header	**BHT**	**Beginning of Hierarchical Transaction**		

Loop	Segment Element	Attributes			Element Name	Instruction
		Set Header				
Header	BHT02	R	ID	2/2	Transaction Set Purpose Code	
Header	BHT03	R	AN	1/30	Reference Identification	Reference Identification is required for Real-time inquiry. CMS will return a 997 if this element is missing.
2100A	**NM1**	**Information Source Name**				
2100A	NM101	R	ID	2/3	Entity Identifier Code	Must submit 'PR' for payer.
2100A	NM102	R	ID	1/1	Entity Type Qualifier	2
2100A	NM103	R	AN	1/35	Last/Organization Name	Organization Name must be 'CMS'
2100A	NM108	R	ID	1/2	Identification Code Identifier	Source Identifier must be 'PI'.
2100A	NM109	R	AN	2/80	Identification Code	Source code must be 'CMS'

4.3.2 Information Receiver Level Structures

Clearinghouses that submit transactions on behalf of the provider must ensure that the correct and validated provider identification is submitted as the Information Receiver. Trading partners must follow the specific requirements for the Information Receiver data:

Loop	Segment Element	Attributes			Element Name	Instruction
2100B	**NM1**	**Information Receiver Name**				
2100B	NM109	R	AN	2/80	Identification Code	Must submit a Medicare Provider Number

4.3.3 Subscriber Level Structures

Trading Partners must ensure that only one patient request is submitted in the Subscriber level for each transaction. Trading partners must follow the specific requirements for the Subscriber Level data:

Loop	Segment Element	Attributes			Element Name	Instruction
2100C	**NM1**	**Subscriber Name**				
2100C	NM103	R	AN	1/35	Subscriber Last Name	Full Last name is required for Beneficiary Identification
2100C	NM104	R	AN	1/25	First Name	Full First name is required for Beneficiary Identification
2100C	NM108	R	ID	1/2	Identification Code Identifier	Subscriber Identifier must be MI.
2100C	NM109	R	AN	2/80	Identification Code	Beneficiary Health Insurance Claim Number (HICN) is required for

Loop	Segment Element	Attributes			Element Name	Instruction
						Beneficiary Search or RRB (Rail Road Beneficiary number). This element must exactly match the ID on the patient's Medicare card.
2100C	**DMG**	**Subscriber Demographic Information**				
2100C	DMG02	R	AN	1/35	Subscriber Date of Birth	Date of Birth is required for Beneficiary Identification
2100C	**DTP**	**Subscriber Date**				If Subscriber Date is not received, CMS will return the most current eligibility data of the patient, if coverage is indicated.
2100C	DTP01	S	ID	3/3	Date/Time qualifier	Must be 307 or 472 to query eligibility and benefit data for a certain period.
2110C	**EQ**	**Subscriber Eligibility Inquiry Information**				CMS will accept any Service Type Code.
2110C	**DTP**	**Subscriber Eligibility Benefit Date**				CMS will not provide specific benefits for corresponding EQ if dates are sent with this loop. All benefits will be provided as of the 2100C DTP requested dates.

4.4 Proprietary Error Messages

Proprietary messages will be sent only when the ISA segment of the 270 cannot be read making it impossible to formulate an ISA segment for a response. The proprietary message will return error codes and description. Trading Partners may contact the Help Desk for assistance with Proprietary Errors. The format for the proprietary message is described below:

Data Element	Description	Size	Comments
Transaction ID	Transaction ID	04 characters	Data content will be "HETS"
Transaction Reference Number	Trace Identification No or (ISA13)	30 characters	Reference Number that Trading Partner can use to call Helpdesk.
Date Stamp	System Date	08 Characters	CCYYMMDD
Time Stamp	System time	09 Characters	HHMMSSSSS
Response Code	Type of Error	02 Characters	See Below
	ISA	" I"	Incoming ISA cannot be read
	Delimiter	" D"	Delimiter could not be identified
Message Code	Error Code	08 Characters	Error code

Message Text Description	Error Descriptions	70 Characters	Error description

Proprietary Message Codes and Description

Response Code	Message Code	Message Text Description
I	HTS00101	Transmission Wrapper SOH (hex=01) is invalid or missing
I	HTS00102	Transmission Wrapper STX (hex=02) is invalid or missing
I	HTS00103	Transmission Wrapper ETX (hex=03) is invalid or missing
I	HTS00104	Transmission Wrapper Length is missing or not numeric
I	HTS00105	Transmission Wrapper Length does not match 270 transaction length
I	HTS00106	Transmission data is invalid or not ASCII or not EBCDIC
I	HTS00107	HIPAA 270 transaction does not start with ISA (Segment ID)
D	HTS00151	4th Character in the 270 Transaction is not a valid Element Separator
D	HTS00152	The end of the ISA segment is not a valid Segment terminator
D	HTS00153	The Component Element Separator (ISA16) is not a valid or missing

4.5 Eligibility Response 271 Transaction Set Data Clarifications

The system will return eligibility information for a patient that has active Medicare Part A and/or Part B coverage. The ISA envelope will be formatted based on the information provided during the EDI Agreement and Registration process.

4.5.1 Security and Validation Edits

The system will validate that the Clearinghouse or Provider has been established in the Trading Partner Management System prior to processing the 270 transaction. If Trading Partner (ISA06) cannot be validated, the system will return a TA105=006 Error for Invalid Interchange Sender ID.

Trading Partners may not send transactions to be executed as Production (ISA15=P), until Testing has been accomplished and approval to submit production transaction has been given. The system will return a TA105=020 Error for Invalid Test Indicator Value.

4.5.1 Information Source and Receiver Level data

The system will return only one Transaction Set Header for each eligibility response. Trading Partners will receive the following AAA03 codes for Source and Receiver errors:

Loop	Element Name	Element Name	Instructions	Element Name
2100A	AAA01 Yes/No Condition	AAA02 Qualifier Code	AAA03 Reject Reason Code	AAA04 Follow up Action
2100A	N	NU	04 – when 270 contains more than one	C

			beneficiary request (ST – SE) or; when 270 contains more than one 2100C Subscriber loop.	
2100A	Y	NU	42 – When the system is unable to respond due to: • System is unavailable • Unable to format a response to the Trading Partner within 60 seconds • System hardware or software component(s) have failed • Databases have failed to respond	R
2100A	N	NU	79 – When 2100A NM109 Source identification is other than 'CMS'.	C
2100A	N	NU	T4 - when 2100A NM109 or NM103 is missing data for Information Source.	C
2100B	N	NU	43 – When 270 is missing the 2100B NM109 for Provider Identification.	C

4.5.2 Subscriber Level data

The system will return only one Subscriber Level detail for each eligibility response. The system will use all four search criteria elements Patient Medicare Number, Patient Last Name, Patient First Name and Patient Date of Birth to match a beneficiary record on the database.

The system will return the 2100C REF Segment from the 270 where REF01=EJ and REF02=Patient Account Number. REF03, description for the account, will not be returned even if sent on the 270 transaction.

The system will return the beneficiary address only if it is available in the CMS Eligibility database.

The system does not require the gender field to complete a Subscriber search; however, if sent in a 270 transaction gender is a verified field and could cause transactions to reject. Trading Partners will receive the following AAA03 codes for Subscriber errors:

Loop	Element Name	Element Name	Instructions	Element Name
2100C	AAA01 Yes/No Condition	AAA02 Qualifier Code	AAA03 Reject Reason Code	AAA04 Follow up Action
2100C	N	NU	58 – When the 270 2100C DMG02 element is missing Subscriber DOB.	C

2100C	N	NU	63 - When the 270 2100C DTP03 element date(s) is in the future.	C
2100C	N	NU	64 – When the 270 2100C NM109 element is missing the Subscriber ID.	C
2100C	N	NU	65 – When the 270 2100C NM103 element is missing the Subscriber last name or; does not match the Beneficiary Last name on the database.	C
2100C	N	NU	65 – When the 270 2100C NM104 element is missing the Subscriber first name or; does not match the Beneficiary First name on the database.	C
2100C	N	NU	66 – When the 270 2100C DMG03 Subscriber Gender code does not match the Beneficiary Gender code on the database.	C
2100C	N	NU	67 – When the 270 2100C NM109 Subscriber ID cannot be found in the Beneficiary database	C
2100C	N	NU	71 - When the 270 2100C DMG02 Subscriber DOB does not match the Beneficiary DOB on the database.	C

4.5.3 Subscriber Eligibility Benefit Information

The system will return a core set of eligibility information for all Service Type Codes; or if Service Type Code is not provided on the 270 transaction. See Appendix 'A' for Core Eligibility Data.

The system will return additional eligibility information along with the core eligibility data for certain Service Type Codes. See Appendix 'B' for Service Type Codes that will return additional eligibility information on the 271.

The system will accept multiple Service Type Codes on a 270 transaction. The system will return one core set of eligibility data with EB03=30 when multiple Service Type Codes are sent requesting same core eligibility information. The system will return multiple EB loops based on based on the Type of Service Code request.

The system will return an EB01=6 for inactive beneficiary if the Subscriber is ineligible based on the following conditions:

- The beneficiary in the database does not have any entitlement information.
- The beneficiary has been determined to be an unlawful resident in the United States.
- The beneficiary has been deported from the United States.
- The beneficiary has been incarcerated and therefore not eligible for Medicare.
- The beneficiary is deceased and therefore not eligible for Medicare.

The system will return current eligibility information when no specific date request has been made on the 270 transaction (thru 2100C DTP03 date).

271 INFORMATION RETURNED	LOOP	SEGMENT	ELEMENT	DATA VALUE
Reference Number		BHT	BHT03	Same as 270
Source ID	2100A	NM1	NM109	CMS
Provider Number	2100B	NM1	NM109	Same as 270
Last name	2100C	NM1	NM103	Same as 270
First Name	2100C	NM1	NM104	Same as 270
Middle Initial	2100C	NM1	NM105	Same as 270
HIC Number	2100C	NM1	NM108 NM109	Same as 270
Date of Birth	2100C	DMG	DMG02	Same as 270
Sex Code	2100C	DMG	DMG03	Same as 270
Part A/B Entitlement/Term Dates	2110C	EB	EB01 EB02 EB04	1 IND MB or MA
	2110C	DTP	DTP01 DTP02 DTP03	307 RD8 or D8 Date
Beneficiary Address Data	2100C	N3	N301 N302	Address Line 1 Address Line 2
	2100C	N4	N401 N402 N403	City Name State Code Postal ZIP Code

271 INFORMATION RETURNED	LOOP	SEGMENT	ELEMENT	DATA VALUE
Deductible - Part B	2110C	EB	EB01 EB03 EB04 EB06 EB07	C 96 MB 29 Amount
	2110C	DTP	DTP01 DTP02 DTP03	349 D8 Applicable year (use 1231 for month/day)
MCO Data	2110C	EB	EB01 EB03 EB04	R 30 HN
	2110C	REF	REF01 REF02	18 MCO ID Code
	2110C	DTP	DTP01 DTP02 DTP03	290 RD8 or D8 Date
	2120C	NM1	NM101 NM102 NM103	PRP 2 Name
	2120C	N3	N301 N302	Address Line 1 Address Line 2
	2120C	N4	N401 N402 N403	City State Code ZIP Code
Home Health Data – HHEH Each Date and Message segment will be a unique EB Loop	2110C	EB	EB01 EB03 EB04 EB06	X 44 MA 26
	2110C	DTP	DTP01 DTP02 DTP03	193 194 D8 Date
	2110C	MSG	MSG01	HHEH Start Date HHEH End Date HHEH DOEBA HHEH DOLBA

271 INFORMATION RETURNED	LOOP	SEGMENT	SEGMENT NUMBER	DATA VALUE

MSP Data May return multiple occurrences	2110C	EB	EB01 EB02 EB03 EB04	R Ind 30 12, 13, 14, 15, 16, 41, 42, 43, 47
	2110C	REF	REF01 REF02	IG Policy Number
	2110C	DTP	DTP01 DTP02 DTP03	290 RD8 or D8 Date(s)
	2120C	NM1	NM101 NM102 NM103	PRP 2 Name
	2120C	N3	N301 N302	Address Line 1 Address Line 2
	2120C	N4	N401 N402 N403	City State Code ZIP Code

Appendix A Service Type Codes – Additional Data

Service Type Code	Send additional 271 data Based upon Type of service
14- Renal Supplies in the Home	2110C, EB01=D, EB03=14, EB04=MB ESRD Effective date DTP01=356, DTP02=D8, DTP03= Date, Transplant discharge Date, DTP01=198, DTP02=D8, DTP03=date, MSG01=transplant discharge date
15 – Alternate Method Dialysis	Method 1 2110C, EB01=D, EB03=15, EB04=MA ESRD Effective date DTP01=356, DTP02=D8, DTP03= Date, Transplant discharge Date, DTP01=198, DTP02=D8, DTP03=date, MSG01=transplant discharge date
42 – Home Health Care	2110C EB01=X, EB03=42, EB04=MA 2120C NM101=PR, NM102=2, NM103=1 of the following: CAHABA GBA, Associated Hospital Service, Palmetto GBA, United Government Services, WI, United Government Services, Ca NM108=PI, NM109=1 of the following: 00011, 00180, 00380, 00450, 00454 Home Health Provider 2120C PRV01=HH, PRV02=9K, PRV03=provider #
44 – Home Health Visits	Same as #42 except EB03=44
47 – Hospital	Hospital days remaining 2110C EB01= F, EB03=47, EB04=MA, EB06=29, EB09=DY, EB10=days Deductible 2110C EB01=C, EB03=47, EB04=MA, EB06=29, EB07=Deductible Amt Co-insurance Hospital days remaining EB01=A, EB03=48, EB04=MA, EB06=29, EB07=amt. For year EB09=DY, EB10= days Lifetime Reserve Days EB01=K, EB03=47, EB04=MA, EB06=33, EB09=LA, EB10= Days
48 – Hospital – Inpatient	Same as #47 except EB03=48
49- Hospital – Room & Board	Same as #47 except EB03=49
54 – Long Term Care	Same as #47except EB03=54
70- Transplants	Same as #47 except EB03=70
AA – Rehabilitation – Room & Board	Hospital days remaining 2110C EB01= F, EB03=AA, EB04=MA, EB06=29, EB09=DY, EB10=days Co-insurance Hospital days remaining

Service Type Code	Send additional 271 data Based upon Type of service
	EB01=A, EB03=47, EB07=amt. For year EB04=MA, EB06=29, EB09=DY, EB10= days Lifetime Reserve Days EB01=K, EB03=47, EB04=MA, EB06=33, EB09=LA, EB10= Days SNF Days Remaining 2110C EB01=F, EB03=AG, EB04=MA, EB06=29, EB09=DY, EB10=SNF days Remaining, Co-insurance SNF days Remaining 2110C EB01 =A, EB03=AG, EB04=MA, EB06=29, EB07=amt. For year EB09=DY, EB10=SNF co days remaining
AG – Skilled Nursing Care	SNF Days Remaining 2110C EB01=F, EB03=AG, EB04=MA, EB06=29, EB09=DY, EB10=SNF days Remaining, Co-insurance SNF days Remaining 2110C EB01 =A, EB03=AG, EB04=MA, EB06=29, EB07=amt. For year EB09=DY, EB10=SNF co days remaining)
AH – Skilled Nursing Care – Room & Board	Same as AG except EB03=AH